Current Review

Psychosocial reactions to physical illness

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Recently medical educators have emphasized the need for physicians to acquire the skills to deal with psychologic aspects of patient care. To facilitate this task a descriptive schema is presented for use in evaluating patients' psychosocial reactions to physical illness. Three core components of such reactions are: the personal meaning of illness, emotional responses to illness and modes of coping with illness. Clinical application of this schema may help with patient management and prevent psychiatric complications of physical illness.

Récemment les professeurs de médecine ont souligné la nécessité pour le médecin d'acquérir les compétences requises pour s'occuper des aspects psychologiques des soins aux malades. Dans le but de faciliter cette tâche on présente un schéma descriptif pouvant être utilisé dans l'évaluation des réactions psychosociales du malade aux malaise physiques. Trois composantes essentielles de ces réactions sont: la signification personnelle de la maladie, les réactions affectives à la maladie et les façons d'affronter la maladie. L'application clinique de ce schéma peut contribuer au traitement du malade et prévenir les complications psychiatriques des malaises physiques.

Much has been written in recent years about the need for physicians to consider the psychosocial aspects of illness. The American Board of Internal Medicine requires internists to be able to "recognize and be attentive to the patient's emotional needs and recognize their potential influence on the symptoms and course of the illness".[1] Similarly, Hollenberg and Langley[2] recommended that the general internist spend an elective period in psychiatry so as to become "more proficient in recognizing how emotional illness modifies the usual features of organic disease". These salutary recommendations clearly aim at correcting the predominantly technologic bias in modern health care, or what Reiser,[3] a medical historian, called the "reign of technology". In a trenchant paper he argued for a more balanced approach to medical practice, one that encompasses a humanistic as well as a strictly scientific perspective: "Reverence for objective evidence", he contended, "has led to a continued and serious decline in training physicians to take histories or listen to patients; such data, subjective in content, personal, biased, is viewed as inferior".[4] His contention appears to be borne out by a recent study of house officers who failed to detect 79% of the noncompliance in taking prescribed medications, 34% of psychiatric disturbances and 76% of recent stressful life events in a sample of 235 medical patients.[5]

Thus, a discrepancy seems to exist between the stated training objectives for internists, which emphasize the need to consider psychosocial factors in medical diagnosis and treatment, and the outcome of training as manifested in actual practice. This discrepancy could be counteracted by offering medical students and physicians a conceptual and practical schema that would help them recognize and understand patients' psychosocial reactions to physical illness and injury. I have formulated such a theoretical framework[6-8] and will summarize it here.

Definition of psychosocial reaction

Psychosocial reaction to illness refers to a set of cognitive, emotional and behavioural responses induced in every sick person by all the illness-related information they receive.[7,8] Such information has three main sources: somatic perceptions, the patient's own knowledge of and beliefs about disease, and the messages the patient receives from the social environment and especially the doctor's statements.

Psychosocial reaction may be regarded as an integral component of every episode of physical illness and hence as ubiquitous. It may be viewed as normal or not, depending on the currently prevalent notions of normality. For example, whether a patient's depressed mood is seen as a normal reaction to illness or as a manifestation of a depressive or adjustment disorder, and hence abnormal, is to some extent a value judgement whose undue subjectivity may be reduced by recourse to appropriate diagnostic criteria. A welcome feature of the American Psychiatric Association's new classification of mental disorders (DSM-III) is its explicit criteria for the diagnosis of all the disorders.[9] As a result the arbitrariness of the diagnostic process in psychiatry has been diminished, though not eliminated.

Key components of psychosocial reaction

A patient's psychosocial reaction, whether judged to be normal or not,

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influences for better or worse the course and outcome of any serious, and especially chronic, physical illness. Hence, it is desirable to observe, describe and classify such reactions, and to study their determinants, so that physicians have a clear descriptive framework applicable to clinical work. The doctor may thus be helped to identify and understand a given patient's reaction, and to be better able to promote optimal recovery from or adaptation to the illness.

A psychosocial reaction is conceptualized here as a set of responses to illness-related information. The patient appraises the information, consciously and unconsciously, and by this cognitive process arrives at its personal meaning for him or her. That evolved meaning influences in turn the patient's emotional responses and coping behaviour. Thus, the meaning of illness, the emotional responses to it and coping with it are the key components of every patient's psychosocial reaction to physical illness and form the proposed schema for clinically evaluating that reaction.

Meaning of illness

"Meaning" in this context connotes the subjective significance for the patient of all the illness-related information that impinges on him or her.[7,8] Patients appraise the information in the light of their personal experience, knowledge, values, beliefs and needs. The evaluation continues throughout the course of every illness, but meanings may change as the information received by the patient and his or her condition change. At any given point, however, one meaning is likely to predominate and influence the patient's emotional state and coping behaviour. To help the physician determine what the illness means to the patient and hence to understand better the patient's feelings and behaviour, I will describe four major categories of meaning most often encountered in clinical practice.[6-8]

Challenge or threat: For many patients illness signifies either a challenge or a threat, like any other vicissitude of living. A patient who views illness primarily as a challenge will try to deal with it actively and to master it by any available means. Such an attitude is reflected in the patient's emotional state and behaviour: the personal impact of pain, suffering or disability is neither denied nor exaggerated, and the patient generally does not manifest excessive and thus maladaptive emotional responses. Similarly, coping behaviour tends to be relatively rational and flexible, as the situation demands. Timely seeking of medical advice and treatment and cooperative compliance with it, flexible modulation of physical activity, purposeful rather than obsessive seeking of relevant information, and efforts to compensate for impaired or lost functions are typical examples of patients' adaptive behaviour. Such a meaning and an attitude are the most desirable, and physicians should deliberately encourage them.

Viewing illness predominantly as a threat is likely to elicit corresponding emotions of anxiety or fear, and sometimes anger. The usual behavioural responses are fight, flight and withdrawal. Some patients literally view illness as an invading enemy; our language reflects this when we speak of the "conquest" of cancer or of "combatting" disease. Such an active stance may be adaptive, provided the patient does not deny that the threat is real and hence ignore the illness and live as if it did not exist. Occasionally a patient may become frankly paranoid, viewing the illness as the work of malevolent forces or people and displaying a suspicious, angry and hostile attitude towards others, including physicians. Some literally freeze with fear and fail to make necessary decisions and to act.

Loss: Many patients view their illness in terms of losses, both concrete and symbolic, and feel and act accordingly. Concrete losses involve body parts and functions. Symbolic ones concern personally significant values and needs, such as security, pleasure, gratification and self-esteem. Loss of self-esteem appears to be a key determinant of the depressive disorders that are observed relatively often in the physically ill. To be seriously or chronically ill is enough burden in itself, but to feel that one is devalued as a result of the illness, and hence to suffer a loss of self-esteem, not only is unnecessary and irrational but also magnifies the burden.

A normal emotional response to loss is grief, characterized by a state of sadness, discouragement, hypochondriasis, lack of interest in activities, inability to experience joy and pleasure, and brooding about what one has lost. There is no clear boundary between normal grief and a depressive disorder, as the symptoms of these states tend to overlap. The fact that depressive disorders are the commonest psychiatric complications of physical illness suggests that loss, especially loss of self-esteem, as the meaning of illness is quite prevalent in our culture.[10]

The coping behaviours associated with grief and depression may include withdrawal, helpless attention-seeking, hostile confrontations with others, noncompliance with medical treatment, substance abuse and suicide.

Gain or relief: For some patients being ill signifies, consciously or not, a welcome respite from the demands and responsibilities of social roles, or from a difficult interpersonal situation or economic hardship. Illness may also help attenuate an inner conflict — over sexual or dependent strivings, for example — by allowing the patient to rationalize and legitimize either avoidance or expression of the conflict-laden impulses. In this context there is a primary or a secondary gain from the illness.

A patient for whom the illness signifies gain or relief may appear to be curiously indifferent, or even cheerful, in the face of serious disability. Paradoxically, such a patient may clamour for relief and protest his or her desire to get well, yet in various more or less subtle ways sabotage the doctor's efforts to help. Noncompliance with treatment is common in such patients, some of whom may manifest conversion symptoms and generally cling to the sick role. Doctors tend to resent such patients: they make them feel ineffectual and helpless. A highly ambivalent, if not overtly hostile, doctor–patient relationship is likely to ensue. Insight into the motives behind the patient's behaviour may help the physician deal with the patient more rationally and effectively.

Punishment: There are several va-

riants of this meaning. The patient may regard the illness as either a just or an unjust punishment and as one allowing redemption or not. The associated emotions reflecting the specific meaning may range from depression and shame to anger or elation. The paramount issue here is the presence and degree of a sense of guilt. If the patient views the illness as a just punishment for real or imaginary transgressions, then he or she may surrender to it passively or even eagerly. Such a patient often makes no attempt to get well and may even die despite effective medical treatment. By contrast, a person who views the illness as an undeserved punishment is likely to display anger and bitterness, perhaps against family members or doctors. Hostile, litigious or even paranoid behaviour may result. Finally, if the patient views the illness as a just punishment and one that promises redemption, he or she may submit to it temporarily yet display hope, optimism and occasionally even elation.

Determinants of meaning: These four categories of meaning of illness do not, of course, exhaust all the possible variants[6] but encompass those most often seen in clinical practice. To understand better why a given patient evolves one of these meanings one needs to consider briefly their main determinants. At this point we are advancing from description and classification to explanatory hypotheses. I propose that there are four main groups of determinants or causative factors: intrapersonal, interpersonal, illness-related, and sociocultural and economic.[7,8]

- Intrapersonal factors. These include personality, past experience and emotional state of the patient at the time of illness onset. Personality, or the enduring tendencies of an individual to react to and process stimuli and to act in characteristic ways, encompasses the person's cognitive–perceptual style as well as his or her psychodynamic configuration. Cognitive–perceptual style refers to the person's characteristic manner of responding to and processing information. Some individuals habitually and automatically augment the intensity of the perceived stimuli; others reduce it.[11] The augmenters experience pain and other illness-related perceptions as more intense and distressing than do the reducers. Augmenters are also more likely to view illness as a threat or loss than are the reducers, whose distress tends to be automatically attenuated and, hence, easier to disregard or even deny. By the patient's psychodynamic configuration I mean his or her predominant needs, strivings, conflicts, defence mechanisms, coping style, self-esteem and proneness to guilt, depression and anxiety. A person, for example, whose chief needs, strivings and sources of self-esteem involve ceaseless intellectual or physical activity and achievement is likely to react with an urgent sense of threat or loss to any illness interfering with the valued activity. As a result, anxiety or depression or both, often associated with feelings of guilt or self-devaluation, can emerge. The patient's past experience with illness also influences the evolved meaning. For example, if being ill as a child was rewarded or, on the contrary, looked down on as weakness and disparaged by the parents the patient may habitually respond to illness as gain or threat respectively.

Finally, the individual's emotional state, say a depressive mood occasioned by a personally significant loss, at the time of illness onset is likely to influence the evolved meaning of illness.

- Interpersonal factors. These include support from family members and a good doctor–patient relationship. These supports are currently viewed as factors protecting one against adverse effects of stressful life events,[12] and when they are available during illness the patient is more likely to react to the illness as a challenge rather than an overwhelming threat or loss.
- Illness-related factors. The subjective importance for the patient of the body part or function affected by illness plays an important role. Generally the greater the personal, sometimes idiosyncratic and unconscious, value of the lost or disordered body part or function is for the patient, the more likely it is that the illness is seen as a grave threat or loss.[7,8]
- Sociocultural and economic factors. People hold diverse beliefs about and attitudes toward illness and specific diseases. These are influenced in part by their education and sociocultural background. For example, in our culture, venereal diseases, epilepsy and cancer carry the connotation of social stigma,[13] and their victims not infrequently view the illness as a loss, threat or punishment. If the economic consequences of illness lead to a drastic lowering of the patient's standard of living or to abandonment of some cherished life goals, then a strongly negative appraisal of the illness is likely to ensue.

Emotional responses to illness

A patient's emotional response to illness is inseparably linked to its meaning for him or her. Moreover, the kind of emotional response may have a feedback effect on the meaning itself — as, for example, when intense anxiety or depression adds to the burden of the illness and reinforces its meaning as threat or loss. Anxiety, grief, depression, shame, guilt and anger are the commonest emotions encountered clinically, and they may occur in various constellations and temporal sequences. They vary not only in their distinct quality but also in their intensity, duration, physiologic concomitants and appropriateness to the objective aspects of the illness and situation.

The commonly seen negative emotional responses to illness are not in themselves abnormal, and there is no sharp boundary between them and the corresponding depressive and anxiety disorders, which are greater in intensity and duration. What matters in practice is the impact of the evoked emotions on the patient's illness and distress as well as on his or her behaviour. Intense and sustained anxiety, for example, is liable to have a harmful effect on a cardiac patient. Anxiety or depression may elicit maladaptive defence mechanisms, such as denial or regression, which may make the patient noncompliant or excessively dependent, which in turn will interfere with recovery or rehabilitation. Some patients abuse alcohol or sedatives in an attempt to relieve emotional distress.

Thus, emotional responses have an important effect on the patient's

manner of coping with the illness, and ultimately on its course and outcome. Clinical assessment of a patient's emotional state is sometimes difficult, as common symptoms of depression (e.g., insomnia, fatigue and anorexia) may be difficult to tell apart from those of the disease itself.

Coping with illness

Coping may be defined as the totality of the cognitive and behavioural strategies employed by the sick person to deal with the demands imposed by the illness.[6] It may be adaptive or not in terms of its effects on the recovery from illness and the patient's well-being. How a patient copes with the illness reflects his or her habitual tendencies to deal with stressful life events in individually characteristic ways. These enduring reaction patterns can be categorized according to their style.

The two chief cognitive coping styles are minimization and vigilant focusing.[6] Minimization implies a tendency to habitually play down the personal significance and emotional impact of a stressful event. This style is analogous to the cognitive–perceptual style of reducing. Individuals who cope by minimization may exhibit various degrees of denial of the subjective importance of threat or loss represented by the illness. Vigilant focusing, in contrast, is a tendency to respond to stressful events, threats or losses with a high level of attention and concern that may range from purposeful and rational to exaggerated and obsessive.

In the behavioural sphere there are three major coping styles: tackling, or actively dealing with stressful events, including illness; capitulating, or submitting to such events and being passive or overly dependent; and avoiding, or attempting to get away from the event by withdrawing or fleeing.[6]

A patient's dominant coping styles are reflected in his or her communication and action (or inaction) from the time he or she perceives symptoms, suffers an injury or receives a diagnosis. Medical sociologists refer to this as "illness behaviour".[14] The timing of seeking medical advice and the manner and language with which the patient deals with the sick role[15] are all overt manifestations of coping styles and related strategies. These patterns of behaviour influence, and are influenced by, the responses of the key persons with whom the patient interacts, notably family members and doctors. These interactions constitute the social dimension of the psychosocial response to illness.

Conclusion

I hope that this proposed schema and taxonomy of psychosocial reactions to physical illness will help physicians in their clinical work with patients, especially the chronically ill and disabled. For optimal overall management every such patient needs to be evaluated in terms of the chief meaning of illness, the emotions engendered by it, and the coping styles and strategies displayed. Such an assessment should help the doctor provide more effective patient care as a result of clearer understanding of the patient's behaviour and enhanced ability to influence it for optimal physical and social recovery. Moreover, the physician will be better able to predict, and sometimes prevent, the development of psychiatric complications of illness through timely intervention. Such medical care would balance the scientific and humanistic approaches.

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Mind and body

No argument is needed to show what transforming power the mind can exert. The energy set free by the magic agencies of hope, courage, desperation, fanaticism, or by the enthusiasm for a great cause, may reveal the possession of a force undreamed of, or so husband the resources of the body as to keep the flame of life burning for a time when the oil seems exhausted.

—James J. Putnam (1846–1918)